Iowa Board of Medicine
400 SW 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

Hospital Privilege Verification

Applicant: Submit this form to each hospital where you held privileges within the last five years. Complete the top portion and page two of the form only and submit the form to the hospital.

Hospital: Complete and mail the form directly from the hospital to the Iowa Board of Medicine. Any processing fees are the applicant's responsibility.

Applicant's Name (Print Legibly): _____

Applicant's Date of Birth (Month/Day/Year): _____

It is hereby certified that _____
(Name of Applicant)

had hospital privileges at _____
(Name of Hospital)

located at _____
(Address, City, State, Zip, Country)

From _____ To _____
(Month/Year) (Month/Year)

Was any disciplinary action ever taken against the applicant?
Yes_____ No_____
If yes, provide details of the disciplinary action and a copy of any documentation related to the event.

Is there any derogatory* information on file?
Yes_____ No_____
If yes, provide details of the derogatory information and a copy of any documentation related to the event.
*Derogatory information can include probation, investigation, remediation, and/or other disciplinary actions.

Institutional Seal

If the institution does not have an official seal, the form must be notarized.

Completed by the Medical Staff Office:

Print Name: _____

Signature: _____

Date (month/day/year): _____ Phone: _____

Fax: _____ E-mail: _____

Authorization for Release of Information—Hospital Privilege Verification

The applicant must sign this form and submit it with the Hospital Privilege Verification form. The hospital may retain this release of information for their own records.

I, _____(print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonably necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is valid until completion of the licensure process. I understand I have the right to revoke this authorization in writing, except to the extent that the IBM has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information."

_____ _____

Signature of Physician Date

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/ drug abuse or mental health information.